State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided X Not Provided

STATE Arkansas
DATE REC'D DEC 07 1992
DATE APP'D DEC 23 1992
DATE EFF OCT 01 1992
HCFA I/D 92-41

A

TN No. 92-41
Supersedes TN No. None-New Page

Approval Date DEC 23 1992 Effective Date OCT 01 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-B
Page 2a

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: January 1, 1992

MEDICALLY NEEDY

1. Inpatient Hospital Services

All inpatient admissions to an acute care/general hospital or rehabilitative hospital will be allowed up to four (4) days of service per admission when determined inpatient care is medically necessary. On the fifth day of hospitalization, if the physician determines the patient should not be discharged on the fifth day of hospitalization, the hospital may contact the Professional Review Organization (Arkansas Foundation for Medical Care, Inc.) and request an extension of inpatient days. The Professional Review Organization (PRO) will then determine medically necessary days. Calls for extension of days may be made at any point from the fourth day of stay through discharge. However the provider must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. Medically necessary inpatient days are available to individuals under age 1 without regard to the four day limit and extension procedures required under the plan. Additionally, a benefit limit of 20 days per State Fiscal Year (July 1 through June 30) is imposed for recipients age 21 and older. No extensions will be authorized. The benefit limit does not apply to recipients under age 21 in the Child Health Services (EPSDT) Program. The benefit limit for State Fiscal Year 1992 will be calculated beginning with dates of service on or after January 1, 1992.

Inpatient hospital services required for corneal transplants and renal transplants are subject to the MUMP procedure and the 20-day benefit limit. Refer to Attachment 3.1-E, Page 1.

Inpatient hospital services required for heart transplants, liver transplants and non-experimental bone marrow transplants are excluded from the MUMP procedure and the 20-day benefit limit. Refer to Attachment 3.1-E, Pages 2 and 3.

Inpatient hospital services required for pancreas/kidney transplants, single lung transplants and skin transplants for burns are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program. Refer to Attachment 3.1-E, Pages 4, 5 and 6.

1. **Inpatient Hospital Services**

   A. **Rehabilitative Hospital**

      1. **Augmentative Communication Device (ACD) Evaluation - Effective for dates of service on or after September 1, 1999, Augmentative Communication Device (ACD) evaluation is covered for eligible Medicaid recipients of all ages. One ACD evaluation may be performed every three years based on medical necessity. The benefit limit may be extended for individuals under age 21.**

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| STATE Arkansas | |
| DATE REC'D 6-28-99 | |
| DATE APPV'D 9-17-99 | A |
| DATE EFF 9-1-99 | |
| HCFA 179 99-10 | |

SUPERSEDES: NONE - NEW PAGE

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

Revised: March 1, 1997

MEDICALLY NEEDY

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2.a. Outpatient Hospital Services

(1) For the purpose of determining amount, duration and scope, outpatient hospital services are divided into four types of services:

- Emergency services
- Outpatient surgical procedures
- Non-emergency services
- Therapy/treatment services

Emergency Services

Prior to payment, emergency services must be approved by the Professional Review Organization (PRO). **The determination of an emergency medical condition will be in compliance with Section 1867 of the Social Security Act.**

Non-emergency services may be necessary in the outpatient hospital setting when qualified physicians are not available in their offices or walk-in clinics to carry out the necessary treatment.

STATE Arkansas
DATE REC'D 01-13-97
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DATE EFF 03-01-97
HCFA 179 97-01

A

SUPERSEDES: TN • 96-12

2.a. Outpatient Hospital Services (Continued)

Since each emergency service must be approved prior to payment, no additional benefit limitations are imposed.

Outpatient Surgical Procedures

Coverage of outpatient surgical procedures are limited to procedures which the Arkansas Medicaid Program has determined to be safe and effective when performed on an outpatient basis.

Since outpatient surgical procedures are limited to approved services, no additional benefit limitations are imposed.

**Treatment/Therapy Services**

**The covered outpatient hospital treatment/therapy services include, but are not limited to the following:**

- **Dialysis**
- **Radiation therapy**
- **Chemotherapy administration**
- **Physical therapy**
- **Occupational therapy**
- **Speech therapy**
- **Respiratory therapy**
- **Factor 8 injections**
- **Burn therapy**

**Treatment/therapy services, are included in the outpatient hospital services limit of twelve (12) visits per State Fiscal Year.**

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician **and nurse practitioner** services
- outpatient hospital therapy and treatment services and related physician **and nurse practitioner** services

For services beyond the 12 visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered to be categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm (code range 140.0 through 208.91); HIV infection (code range 042); renal failure (code range 584.5 through 586); **pregnancy (diagnosis code range 630 through 677, diagnosis codes V22.0 and V22.1 and diagnosis codes V280 through V289)**. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

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| STATE Arkansas<br>DATE REC'D 4-30-99<br>DATE APPV'D 6-18-99<br>DATE EFF 7-1-99<br>HCFA 179 99-04 | A |

SUPERSEDES: TN - 93-29

2.a. Outpatient Hospital Services (Continued)

**Augmentative Communication Device (ACD) Evaluation**

**Effective for dates of service on or after September 1, 1999, Augmentative Communication Device (ACD) evaluation is covered for eligible Medicaid recipients of all ages. One ACD evaluation may be performed every three years based on medical necessity. The benefit limit may be extended for individuals under age 21.**

STATE Arkansas
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DATE EFF 9-1-99
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SUPERSEDES: NONE (NEW PAGE)

2.b. Rural Health Clinic Services

Rural health clinic services are limited to twelve (12) visits a year for recipients age 21 and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist and **certified nurse midwife services.** Recipients will be allowed twelve (12) visits per State Fiscal Year for rural health clinic services, physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, **certified nurse midwife services** or a combination of the **five**. For physician services, medical services provided by a dentist, office medical services furnished by an optometrist, **certified nurse midwife services** or rural health clinic core services beyond the 12 visit limit, extensions will be provided if medically necessary. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Rural Health Clinic core services are defined as follows:

(1) Physicians' services, including required physician supervisory services of nurse practitioners and physician assistants;

(2) Services and supplies furnished as an incident to a physician's professional services;

Services and supplies "incident to" the professional services of physicians, physician assistants and/or nurse practitioners are those which are commonly furnished in connection with these professional services, are generally furnished in the physician's office and are ordinarily rendered without charge or included in the clinic's bills; e.g., laboratory services, ordinary medications and other services and supplies used in patient primary care services.

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| STATE Arkansas<br>DATE RECD 10-26-99<br>DATE APPV'D 10-29-99<br>DATE EFF 12-1-99<br>HCFA 179 98-20 | A |

SUPERSEDES: TN - 98-09

2.b. Rural Health Clinic Services (Continued)

(3) Services of physician assistants, nurse practitioners, nurse midwives and specialized nurse practitioners;

(4) Services and supplies furnished as an incident to a nurse practitioner's or physician assistant's services and

(5) Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the Rural Health Clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the Rural Health Clinic will count against the limit established in the plan for that service.

2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA - Pub. 45-4).

**Effective for claims with dates of service on or after July 1, 1995, federally qualified health center (FQHC) services are limited to twelve (12) encounters per recipient, per State Fiscal Year (July 1 through June 30) for recipients age 21 and older. For federally qualified health center core services beyond the 12 visit limit, extensions will be provided if medically necessary. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.**

**FQHC hospital visits are limited to one day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.**

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DATE APP 04-07-95
DATE EFF 07-01-95
HCFA ID 95-06
A

SUPERSEDES TN 91-21

2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA - Pub. 45-4). (Continued)

***Covered FQHC core services are defined as follows:***

- ***physician services;***
- ***services and supplies incident to physician's services (including drugs and biologicals that cannot be self-administered);***
- ***pneumococcal vaccine and its administration and influenza vaccine and its administration;***
- ***physician assistant services;***
- ***nurse practitioner services;***
- ***clinical psychologist services;***
- ***clinical social worker services;***
- ***services and supplies incident to clinical psychologist and clinical social worker services as would otherwise be covered if furnished by or incident to physician services; and***
- ***part-time or intermittent nursing care and related medical supplies to a homebound individual, in the case of those FQHCs that are located in an area in which the Secretary has determined there is a shortage of home health agencies.***

FQHC ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the FQHC offers such a service, (e.g. dental, etc.). The "other ambulatory services" that are provided by the FQHC will count against the limit established in the plan for that service.

STATE Arkansas
DATE REC'D 12-21-93
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DATE EFF 1-1-94
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Supersedes: TN 91-61